USE THIS FORM OR THE FORM DEVELOPED BY YOUR AGENCY

STATE OF ARIZONA	Supervisor's Report of Injury / Illness (SRI)	WORKERS' COMPENSATION

*****Call *Early Reporting Claims Service* at 1-800-837-8583 once injury is reported (within 24 hours)**
Date/Time Called: Initials
*****In addition to calling the 800#, this form must be completed by the Supervisor. FAX TO: 602-382-2380***

WORKER'S INFORMATION

LAST NAME, FIRST NAME, MI	SOCIAL SECURITY #	EIN #	DATE OF BIRTH (Day, Month, Year)

HOME ADDRESS, CITY, ZIP CODE	HOME PHONE	# OF DEPENDENTS	MARITAL STATUS S M D W

GENDER ☐ Male ☐ Female	EMPLOYEE'S AGENCY/DIVISION/SECTION

EMPLOYEE SUPERVISOR'S LAST NAME, FIRST NAME, MI	SUPERVISOR'S PHONE #	SPVSR DEPT. NAME	EMPLOYEE'S JOB TITLE

WAS WORKER IN YOUR EMPLOY WHEN INJURED? ☐ Yes ☐ No DATE OF LAST HIRE:	WAS WORKER ON OVERTIME WHEN INJURED? ☐ Yes ☐ No	WAS WORKER PAID FOR DAY OF INJURY? ☐ Yes ☐ No	IS WORKER A STATE OF ARIZONA EMPLOYEE? ☐ Yes ☐ No

INJURY / ILLNESS DETAILS

DATE OF INJURY	TIME OF INJURY AM / PM	DATE AND TIME INJURY REPORTED AM / PM

LAST DATE WORKED DATE EMPLOYEE RETURNED TO WORK (IF APPLICABLE)	DID INJURY OCCUR ON EMPLOYER PREMISES? ☐ Yes ☐ No	ADDRESS OR LOCATION OF INCIDENT	PART(S) OF BODY INJURED Left_____ Right____ Both ____

NATURE OF INJURY – (IE, STRAIN, BRUISE, CUT)	EVENT TYPE – (IE, LIFTING, SLIP, TRIP & FALL)	DID INCIDENT RESULT IN ILLNESS? WHAT SYMPTOMS WERE EXPERIENCED?

SOURCE OF INJURY – (IE, AUTOMOBILE, COMPUTER)	MACHINE, TOOL OR OBJECT MOST CLOSELY CONNECTED WITH INCIDENT	WHEN DID ONSET OF SYMPTOMS OCCUR?

INJURY / ILLNESS DETAILS: WHAT HAPPENED?

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IS VALIDITY OF CLAIM DOUBTED? YES / NO
If Yes, please explain:

ON THE SCENE: TREATMENT INFORMATION

PRIMARY OUTCOME **IF TREATMENT REQUIRED, PLEASE CHECK ONE**

☐ **INJURY** ☐ **ILLNESS** ☐ **DEATH** ☐ **MEDICAL** ☐ **FIRST AID** ☐ **NONE**

AT THE SCENE OF INJURY, DID ONE OF THE FOLLOWING OCCUR?

☐ **PATIENT TAKEN TO HOSPITAL** ☐ **PATIENT FELL UNCONSCIOUS** ☐ **FATAL INJURIES SUSTAINED**
☐ **RESUSCITATION REQUIRED** ☐ **AMBULANCE REQUIRED**

IF FIRST AID GIVEN:

DATE OF FIRST AID

TIME OF FIRST AID GIVEN
AM / PM **EMPLOYEE NAME /PH#** **NON EMPLOYEE NAME / PH#**

WHERE WAS INJURY TREATED?

PHYSICIAN / HOSPITAL / FACILITY NAME

NAME OF FACILITY	
PHYSICIAN NAME	
ADDRESS	
CITY, STATE, ZIP	
PHONE NUMBER	

WAS EMPLOYEE HOSPITALIZED OVERNIGHT? YES / NO

BILLING INFORMATION	**PHYSICIAN'S INFORMATION**
Arizona Department of Administration Risk Management Division Worker's Compensation 100 N 15th Avenue, STE 301 Phoenix, AZ 85007 Phone (602) 542-5218 Fax (602) 382-2380 Web Site: www.azrisk.state.az.us	The **Worker's and Physician's Report of Injury** (Form 102) should be completed and signed at the health provider's office. If this form is not filled out, the Industrial Commission and insurance carrier will not be officially notified and claim activity can be delayed.

WITNESSES

# 1 WITNESS		**CONTACT PHONE #**
# 2 WITNESS		**CONTACT PHONE #**

NAME OF OTHERS INJURED IN THE SAME ACCIDENT:

IS PERSONAL PROTECTIVE EQUIPMENT REQUIRED? YES / NO	**WAS IT BEING WORN? YES / NO**

Supervisor's Signature_____**Date**_____**Time**_____
Supervisor's Title_____**Phone #**_____